06/18/	2012 13:19 8	3440913	BNH	T-100	. 1	PAGE	02/09
		AND HUMAN SERVICES (& MEDICAID SERVICES	AC.	•	7/22/12	FORM	: 06/07/2012 APPROVED : 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE S	ETED
YOC	# [445498	B. WING	G		200300000000	C 17/2012
NAME OF P	ROVIDER OR SUPPLIER	0110=11010		STREET	ADDRESS, CITY, STATE, ZIP CODE	-0000 and -000 -000 -000 -000 -000 -000 -000 -0	
BRISTOL	NURSING HOME	acceptable			ORTH STREET TOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 250 SS=D	The facility must proservices to attain or practicable physical well-being of each of the services to attain or practicable physical well-being of each of the facility failed to social services for of five residents review The findings include Resident #1 was according to the facility failed to social services for of five residents review The findings include Resident #1 was according to the findings included Resident	ovide medically-related social maintain the highest I, mental, and psychosocial resident. NT is not met as evidenced record review and interview, provide medically-related one discharged resident (#1) viewed. ed: dmitted to the facility on with diagnoses including; Left-Sided Hemiparesis; Agitans (Parkinson's sion; and Venous Thrombosis. ew of an Initial Social Service February 1, 2012, revealed, ing Hoping to rehab back to	F 2	50	This plan constitutes our creallegation of compliance. However, the submission of allegation of compliance is madmission that a deficiency or that one was cited correct This allegation of compliance submitted to meet the requirements established by and federal law. F 250 Corrective action(s) will be accomplished for those resident found to affected by the deficiency practice Resident #1 no longer resides in facility. Home services are being provided by Choices. A follow up on 5/30/12 was made to the Choices Manager to see if any other	this not an exists tily. e is state ts ent the c call pices	
	(MDS) dated April 1 Resident's functions of Daily Living), ran- total dependence. Resident's range of	ew of a Minimum Data Set 0, 2012, revealed the al status for ADL's (Activities ged from extensive assist to Continued review revealed the motion in the upper and lower actionally impaired on one			assistance was needed. Needs a being met at this time by the Ch Program.		6/18/12
ABORATORY	<u> </u>	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		445498	B. WII	۷G			C 7/ 201 2
	ROVIDER OR SUPPLIER NURSING HOME			20	REET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET BRISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH)	ULD BE	(X5) COMPLETION DATE
F 250	Order dated May 1 Health for ADL's, F (Occupational Theil Medical record revimeeting/Notice data "ReviewTherapy wheelchair, toilet so the Medical record revimentReview for equipmentRole(s) Medical record reviment requipmentRole(s) Medical record reviment requipment requipment requipment requipment requipment and toilet revealed no document of the Health serviment and/or arrangement such as a walker of had a wheelchair produced record reviment requipments for each of the facility made are services, to include arrangements for each of the Medical record reviment for each of the facility made are services, to include arrangements for each of the Medical record reviment for each of the facility made are services, to include a facility for the facility made are services, to include a facility for the facility made are services, to include a facility for the facility made are services, to include a facility for the facility made and services for the facility for the facility made are services, to include a facility for the facility made and services for the facility fo	iew of a Physician's Telephone , 2012, revealed, "Home of (Physical Therapy), and OT rapy)" iew of a Care Plan ed May 3, 2012, revealed, byequipment-elevated walker, eat" iew of a Care Plan dated May "Scheduled to be dischargedHome Health and)SS (Social Services)" iew of the Discharge re dated May 9, 2012, revealed red assistance with transfers air, walking, stairs, bathing, use. Continued review mentation of arrangements for ces, to include PT and OT, hits for equipment for ADL's, r bedside commode (Resident rior to admission and was	F	250	Identify other residents to having potential to be affected by the sa deficient practice and what correaction will be taken On 5/29/12 the Social Worker was educated on job duties and responsibilities by the Quality Ass Nurse. The social worker receive additional training from a license Worker from 6/11/12 through 6/on job duties and discharge plant. Measures/systemic changes implemented to ensure the alleg deficient practice does not reocci. Residents scheduled to be dischabe reviewed Monday through Frithe dally clinical meeting. The discheck off sheet will be completed Social Worker within three to five of the scheduled discharge date. Medical Records Director will aud discharge records weekly for four and then monthly for two month then PRN to ensure compliance.	ame ective s re- surance d Social 13/12 ning. sed aur rge will day in charge l by the e days The lit	6/18/12

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CENTERS FOR	MEDICARE & MEDICAID SERVICES	

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NAME OF PROVIDE	DER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 161 NORTH STREET BRISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
Inte (DS) Corrawa from the Healthe Corpro Res Inte at 1 the Healthe Corpro Corme C/C 483 SS=D When Inte familia by: Bathe	ss) on May 30, 2 inference Room, are the resident in the facility. C DSS failed to malth Services an Resident's discontinued interview vide medically-resident. erview with the A 1:25 p.m., in the facility failed to alth services an Resident's discontinued interview firmed the facility failed to 3:25 p.m. and a st have a discharge planet the facility as the facility failed to facility failed to	Director of Social Services 2012, at 1:15 p.m., in the confirmed the DSS was was going to be discharged ontinued interview confirmed nake arrangements for Home dequipment for ADL's, prior to harge from the facility, wo confirmed the facility failed to related social services for the Administrator on May 30, 2012, Conference Room, confirmed make arrangements for Home dequipment for ADL's, prior to tharge from the facility. We with the Administrator ity failed to provide ocial services for the Resident. CIPATE DISCHARGE: E PLAN Inticipates discharge a resident arge summary that includes a not care that is developed with the resident and his or her sesist the resident to adjust to		250	Corrective actions will be monit to ensure the deficient practice not reoccur: The Medical Records Director will report audit findings to the Qual Assurance Committee monthly. The Quality Assurance Committee made up of the (Administrator, Director of Nursing, Medical Director of Nursing, Medical Director, Social Services Director and Therapy Manager, Activities Director, Social Services Director and Therapy Manager) will make recommend to revise or improve the process determine when compliance has achieved.	will ity ector, y cial lations and	4/18/12

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		445498	B. WING		06/07/2012
	ROVIDER OR SUPPLIER NURSING HOME		26° BF	ET ADDRESS, CITY, STATE, ZIP CODE 1 NORTH STREET RISTOL, TN 37625	
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	Therapy Services, arrangements for eliving for one disciples dents reviewed. The findings included Resident #1 was a January 31, 2012, Closed-Head Injung Epilepsy; Paralysis Disease); Hyperter Medical record rev (MDS) dated April Resident's function of Daily Living), rattotal dependence. Resident's range of extremities were fuside. Medical record rev Progress Note date. Medical record rev Progress Note date.	e Physical and Occupational and failed to provide equipment for Activities of Daily harged resident (#1) of five ded: ded: dmitted to the facility on with diagnoses including y; Left-Sided Hemiparesis; Agitans (Parkinson's nsion; and Venous Thrombosis. iew of a Minimum Data Set 10, 2012, revealed the fail status for ADL's (Activities nged from extensive assist to Continued review revealed the formation in the upper and lower inctionally impaired on one ded May 1, 2012, revealed, arge) with Home Health" iew of a Physician's Telephone (2012, revealed, "Home Activities of Daily Living), PT (2012, revealed, "Home Activities Daily Living)	F 284	Corrective action(s) will be accomplished for those residents found to affected by the deficient practice Resident # 1 no longer resides in a facility. Post discharge plan of carbeing provided by the Choices program. On 5/30/12 a follow up was made to the Choices case mato see if any other assistance was needed. Needs are being met at the time by the Choices program. Identify other residents to having potential to be affected by the sedeficient practice and what correlation will be taken On 5/29/12 the Social Worker was educated on job duties and responsibilities by the Quality Assurance Nurse. The social worker eceived additional training from licensed Social Worker from 6/11, through 6/13/12 on job duties and discharge planning.	the re is call anager this call anager the arms are the cative the ca

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

¢ 06/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

B. WING

445498

	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET
BRISTO	L NURSING HOME		BRISTOL, TN 37625
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	DATE
F 284	Continued From page 4 Medical record review of a Care Plan dated May 3, 2012, revealed, "Scheduled to be discharged homeReview forHome Health and equipmentRole(s)SS (Social Services)" Medical record review of the Discharge Instructions for Care dated May 9, 2012, revealed the Resident required assistance with transfers from the bed-to-chair, walking, stairs, bathing, dressing and toilet use. Continued review revealed no documentation of arrangements for Home Health services, to include PT and OT, and/or arrangements for equipment for ADLs, such as a walker or bedside commode (Resident had a wheelchair prior to admission and was discharge with the wheelchair). Medical record review revealed no documentation the facility made arrangements for Home Health services, to include PT and OT, and/or arrangements for equipment for ADLs. Interview with the Director of Social Services (DSS) on May 30, 2012, at 1:15 p.m., in the Conference Room, confirmed the DSS was aware the resident was going to be discharged from the facility and the facility failed to make arrangements for Home Health Services, to include PT and OT services, and equipment for ADLs. Interview with the Administrator on May 30, 2012, at 1:25 p.m., in the Conference Room, confirmed the facility failed to make arrangements for Home Health services, to include PT and OT services, and equipment for ADL's. C/O #29829	F 2	Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur Residents scheduled for discharge will be reviewed Monday through Friday in the dally clinical meeting. The Social Worker will initiate a post discharge plan of care with input from the resident/family. Prior to discharge a copy will be given to the resident/family to help assist the resident adjust 10 his or her new living environment. The Medical Records Director will audit discharge records weekly for four weeks and then monthly for two months and PRN to ensure compliance. Corrective actions will be monitored to ensure the deficient practice will not reoccur: The Medical Records Director will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance Committee made up of the (Administrator, Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.

DISCHARGE_CHECKLIST

RESIDENT	n en
ANTICIPATED DATE OF DISCHARGE	2
DISCHARGE CARE PLAN MEETING	
NOTES/COMMENTS	
MD ORDERHOME HEALTH ORDER	
CHOICES NOTIFICATION: DATE CONTACT PERSON	
NURSING DISCHARGE EDUCATION COMPLETED	
ORDERS FAXED TO PHARMACY: NAME	FAX #
ORDERS FAXED TO HOME HEALTH AGENCY: NAME	
CONTACT NAME:	
ORDERS FAXED TO DME COMPANY: NAME	
CONTACT NAME:	
DISCHARGE DATE:TRANSPORTED BY:	44.4
DISCHARGE PLAN GIVEN TO RESIDENT/FAMILY	
FOLLOW-UP PHONE CALL (24 HOURS)	
FOLLOW-UP MD APPOINTMENT: MD	DATE:
SIGNATURE	DATE

DISCHARGE INSTRUCTIONS FOR CARE

BNHT-100

You are being discharged to:	☐ Home	a Care Fa	cility (see facility n	ame and ad	dress below) Phone	Andrew and the said
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RESOURCES/SERVICES	Phone	A. Carlotte and A. Carlotte an	Address		City/S	téte/Zip
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State Ombudsman Home Healthcare						
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State Ombudsman Home Healthcare	4700					
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